



Achieving a High Performance Health System

President's Message

2003 ANNUAL REPORT



MISSION STATEMENT

The Commonwealth Fund is a private foundation established in 1918 by Anna M. Harkness with the broad charge to enhance the common good. The Fund carries out this mandate by supporting efforts that help people live healthy and productive lives and by assisting specific groups with serious and neglected problems. The Fund supports independent research on health and social issues and makes grants to improve health care practice and policy.

The Fund's two national program areas are improving health insurance coverage and access to care and improving the quality of health care services. The Fund is dedicated to helping people become more informed about their health care and to improving care for vulnerable populations, such as children, elderly people, low income families, minority Americans, and the uninsured. An international program in health policy is designed to stimulate innovative policies and practices in the United States and other industrialized countries. In its own community, New York City, the Fund also makes grants to improve health care.

About the cover

Dr. Warren Siegel of New York's Coney Island Hospital demonstrates the "Asthma Buddy" handheld computer to one of his young patients. Researchers with the New York City Health and Hospitals Corporation are investigating whether this new "telehealth" technology can help children with asthma manage their condition better, reduce trips to the emergency room, and lower treatment costs.

Photographer: Martin Simon



Karen Davis

Achieving a High Performance Health System

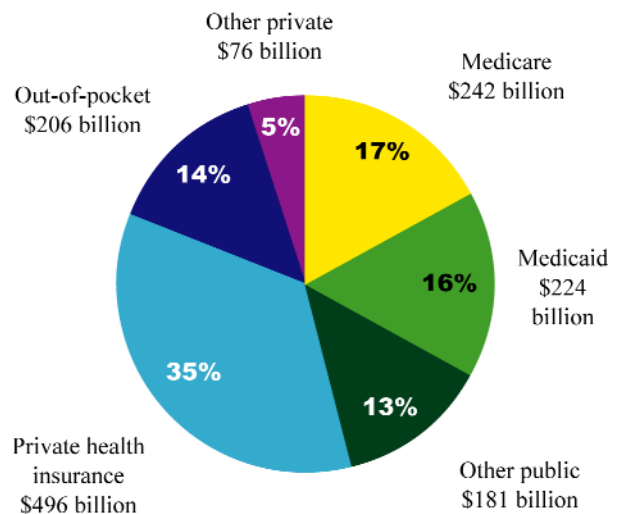
KAREN DAVIS
The Commonwealth Fund

Listening to patients is an important strategy for health care reform. What Americans want is not the cheapest care but the best care, plus clear information and access to health care when they need it. Not surprisingly, they prefer that someone else pay, whether employers or government. But they also want assurances that money is not being wasted on inefficient or ineffective care, excessive profits, or high administrative costs. Those demands are reasonable ones to make on a health care system that is the costliest in the world, consuming an estimated \$1.4 trillion in resources in 2001.

The two major efforts of the 1990s to reform the American health care system – one led by government, the other by employers – ended in failure. The first, laid out in a proposal by the Clinton Administration in 1993, would have provided universal health insurance and fundamental reform of health care delivery and financing. The

Spending on health care in the United States totaled \$1.4 trillion in 2001. Our health care system is expensive, but how well does it perform?

United States national expenditures on health, by source



Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* 22 (January/February 2003).

second, a movement initiated by employers, sought to rein in health care costs by shifting employees into private managed care and giving them

incentives to choose less-expensive plans. The Clinton plan was defeated in the political arena, while the move to managed care foundered as patients chafed at restrictions on their care and physicians and hospitals demanded higher prices or left managed care networks.

In the wake of those experiments, health care costs have again accelerated, more Americans are uninsured, and the quality of care falls far short of what is possible and desirable. Gaps in health insurance coverage remain one of the most important challenges facing the nation. With more than 15 percent of all Americans uninsured and at least another 10 percent with inadequate or unstable coverage, far too many people are unable to obtain care that could keep them healthy and productive.

Improving quality and efficiency requires a strategy different from those advanced in the 1990s. No industry should expect its customers to lead the way in preventing defects, eliminating waste and duplication, improving productivity, and increasing the rate of return on investment, yet that is exactly what the failed reforms expected of health care consumers. Both approaches relied on consumers to make cost-conscious choices but did not demand change – by adopting new payment methods, for example, to reward efficiency and quality – from the health care sector.

Genuine reform must come from within the health care sector itself, as a new generation of reformers learns to tap the potential of modern information technology, measure performance against relevant benchmarks, learn from best practices, and adopt systems, processes, and tools that improve performance. This “supply side” strategy is being pursued by innovative and visionary leaders in

the public and private sectors. We can achieve even more if we make special efforts to increase efficiency, rationalize our fragmented insurance system, and seize opportunities to improve the quality and effectiveness of American health care.

A LOOK IN THE MIRROR

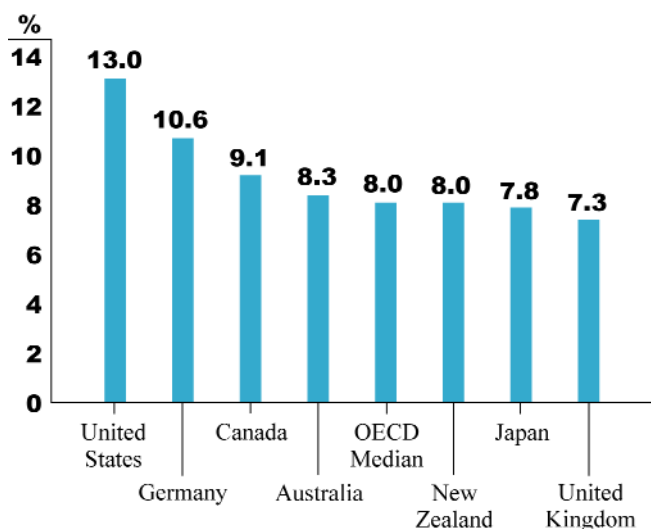
The common belief that the United States has the world's best health care system has for too long undermined serious attempts to improve its quality, accessibility, and efficiency. As Donald Berwick, M.D., president of the Institute for Healthcare Improvement and author of the Fund-published essay *Escape Fire*¹ has said, “We are blind to the enemy.” He estimates that 100 people die every day in American hospitals as a result of medical errors alone.

A candid look at the evidence shows that the American health care system performs less well than those of other countries on many important dimensions. The United States is the only major industrialized nation that fails to provide health coverage for all, yet spending on health care totaled \$4,631 per capita in 2000, 69 percent more than in Germany, 83 percent more than in Canada, and 134 percent more than the average in industrialized nations. Enrollment in private managed care slowed spending in the mid-1990s, but other countries did as well or better in the same period using other cost-containment strategies. Between 1990 and 2000, inflation-adjusted health spending in the United States increased by 3.2 percent a year, compared with an average of 3.1 percent among industrialized nations.

The United States has emphasized private markets and consumer cost-consciousness as

Compared with other major industrialized nations, the United States devotes a much larger share of its gross domestic product to health care.

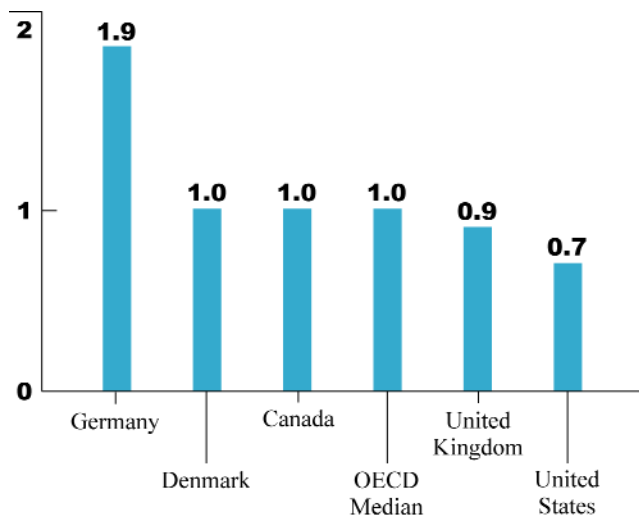
Percent of GDP spent on health care



Anderson et al., *Multinational Comparisons of Health Systems Data, 2002*, The Commonwealth Fund, October 2002, based on OECD health data.

Americans receive fewer days of hospital care than do residents of many other nations, including countries with universal health coverage.

Per capita acute care hospital days in 2000



Anderson et al., "It's the Prices, Stupid: Why the United States Is So Different from Other Countries," *Health Affairs* 22 (May/June 2003), based on OECD health data.

strategies for containing costs, yet our total costs are higher and growing as rapidly.² At 56 percent, private spending as a share of total health care expenditures is far higher in the United States than in other industrialized nations, which average 26 percent. Our per capita out-of-pocket health care spending was \$707 in 2000, more than twice the industrialized nation average of \$328.

A common perception is that other countries control costs by rationing care that patients need. The truth is that Americans receive fewer days of hospital care than residents of other industrialized nations and make about the same number of visits to physicians. We are, however, more likely to undergo specialized procedures, such as coronary angioplasty. In short, health care spending in the United States is higher because we pay higher prices for the same services, have substantially higher administrative costs, and have higher rates of complex procedures.

There is some evidence that greater use of specialized services and leading-edge medications contributes to better outcomes for patients. The United States has fewer deaths from heart attacks, for example, than the average industrialized nation: about 60 each year per 100,000 population, compared with 75 in the United Kingdom and 65 in Australia. Yet our broader record for providing high-quality care is hardly reassuring. According to The Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults, people in poor health are more likely to report medical errors in the United States than in four other English-speaking countries.³ The difference reflects, in part, the greater complexity of care in the United States. Since Americans are more likely to see three or

Americans with health problems are somewhat more likely than patients in other countries to encounter medical errors and lack of coordination. Yet the most significant differences appear in access to needed services.

Percent of population with health problems reporting that:

	AUS	CAN	NZ	UK	US
Medical errors caused serious problems	13	15	14	9	18
Sent for duplicate tests by different health professionals	13	20	17	13	22
In the past two years, did not do the following due to cost:					
Did not fill a prescription	23	19	20	10	35
Did not get medical care	16	9	26	4	28
Did not get recommended test, treatment, or follow up	16	10	15	5	26

The Commonwealth Fund 2002 International Health Policy Survey of Sicker Adults.

more physicians a year and more likely to be taking three or more medications, they have more opportunities to encounter medical or medication mistakes and more chances for lack of coordination to cause problems. They are also more likely to receive duplicate tests and less likely to have their medical records available when they go for care.

The most striking way in which the United States falls short, however, is in access to needed services. Each year since 1998, the Fund's international survey has found that the United States ranks last among five English-speaking countries on measures of equity and first for access problems due to costs. Americans are much more likely than their counterparts in other countries to say they did not visit a physician, fill a prescription, or get a recommended test, treatment, or follow-up care because of costs. Disparities between people in above-average and below-average income groups were greatest in the United States, and the uninsured were much more likely to report problems in obtaining needed care.⁴

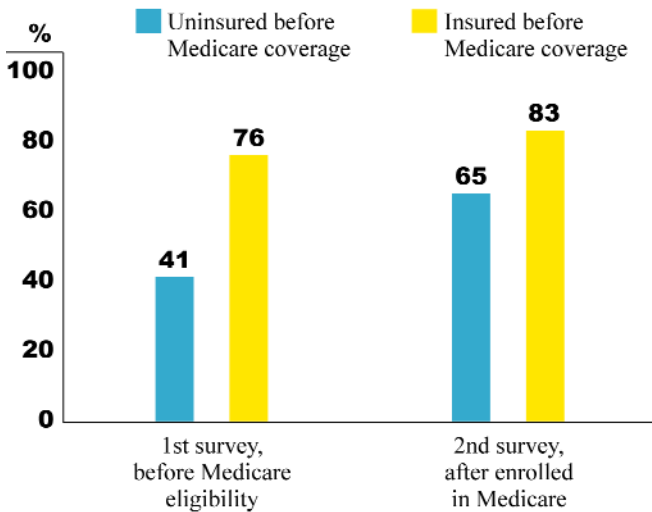
UNCOVERING THE HIDDEN COSTS OF THE UNINSURED

Failing to provide health coverage for all is economically short-sighted. The burdens of that failure fall most heavily on the 44 million Americans who are uninsured. Lack of health insurance shortens productive years of work, allows preventable or detectable conditions to develop into serious and expensive illnesses, and undermines the standard of living of those caught with financially ruinous medical expenses.⁵ The Institute of Medicine estimates that 18,000 people die each year as a direct result of lack of health insurance, making it the sixth leading cause of death among people ages 25-64, after cancer, heart disease, injuries, suicide, and cerebrovascular disease, but before HIV/AIDS or diabetes.

Lack of health insurance also generates hidden costs in lost productivity, earnings, and capacity. The Institute of Medicine estimates that lack of health insurance costs society \$65 billion to \$130 billion annually.⁶ Those costs take a toll on employers, the

A survey of adults ages 60–64 found that those without health insurance were much less likely to get preventive services such as cholesterol screening. The disparities diminished when the group was surveyed again, after becoming eligible for Medicare.

Percent of patients who received cholesterol screening in previous year (by insurance status prior to becoming eligible for Medicare)



Based on data reported in McWilliams et al., "Impact of Medicare Coverage on Basic Clinical Services for Previously Uninsured Adults," *JAMA* 290 (Aug. 13, 2003).

health care system, government, and the American public.

For employers, the full cost of having uninsured workers is not well understood. It is clear, however, that indirect costs are incurred when employees miss work, leave their jobs, or retire early for health reasons. In the coming decades, employers will depend increasingly on a diverse and older workforce. Failure to invest early in access to preventive care will add to likely workforce shortages when the baby boom generation retires.

A study⁷ supported by the Fund found that uninsured older adults ages 60–64 were much less likely than their insured counterparts to receive essential preventive services. The disparities decline

dramatically once they are over age 65, when Medicare eligibility begins.

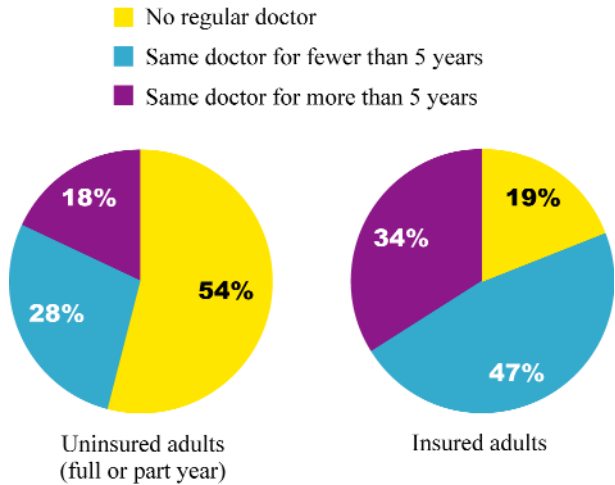
Another Fund-supported study⁸ identified considerable gaps between insured and uninsured adults in the use of medical technology for treating three common conditions: heart attack, cataracts, and depression. Focusing on the 55–64 age group, the authors found that use of the latest treatment technology for each condition was lowest among people without health insurance, producing an estimated \$1.1 billion in costs associated with higher morbidity and mortality. As medical technology continues to improve, the potential losses, both human and economic, will grow if barriers to insurance are not addressed.

The costs to the health care system of treating uninsured patients have not been systematically documented. A recent analysis concluded that the uninsured received approximately \$34.5 billion in uncompensated care in 2001,⁹ but there are hidden costs, as well. Many people who lack insurance do not have a regular doctor and use the health system inefficiently, seeking care in emergency rooms, for example, rather than less expensive primary care settings. The instability of the coverage system – with patients moving in and out of coverage – also generates administrative costs that are not well documented.

Taxpayers pay some of the hidden costs of the uninsured. Federal, state, and local governments support public clinics and make payments to hospitals that provide care to patients without health insurance. Plus, government loses tax revenues when disabled adults or family caregivers are not able to hold jobs and pay taxes on earnings.¹⁰

Findings from the Fund's 2001 Health Care Quality Survey show that insurance status has a profound effect on whether or not Americans have a regular doctor.

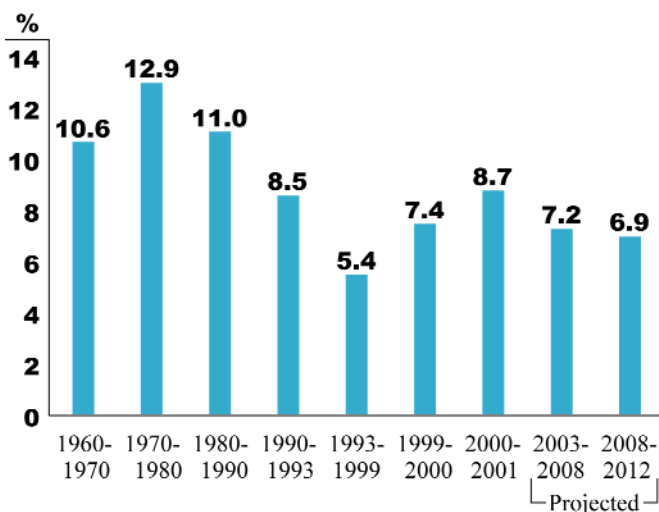
Insurance status and relationship with a regular physician



Davis et al., *Room for Improvement: Patients Report on the Quality of Their Health Care*, The Commonwealth Fund, April 2002.

The annual rate of growth in health expenditures dropped in the 1990s but has risen again in recent years.

Average annual percentage growth in United States health expenditures



Levit et al., "Trends in U.S. Health Care Spending, 2001," *Health Affairs* 22 (January/February 2003); and Heffler et al., "Health Spending Projections for 2002-2012," *Health Affairs Web Exclusive* (February 7, 2003).

Finally, inadequate health care for the uninsured generates hidden costs borne by the general public. Contagious diseases that go untreated because a sick person lacks insurance threaten the health of the entire population. A teaching hospital or medical center that is financially strained by caring for the uninsured may be less able to provide high-level burn or cancer care or to respond to public health threats such as SARS or terrorism.¹¹ An emergency room with a high volume of uninsured patients may need to divert patients needing urgent care to other institutions.

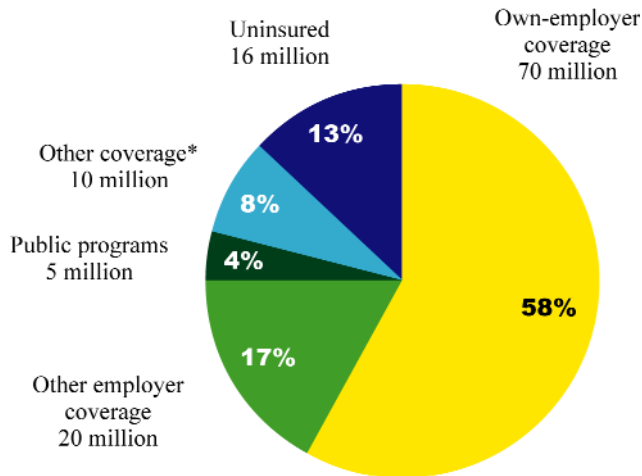
RATIONALIZING A FRAGMENTED INSURANCE SYSTEM

Rising health care costs are a major concern for policymakers, employers, health care leaders, and insured and uninsured Americans alike. Health insurance premiums are growing by 10-15 percent a year, as insurance companies increase profits and reserves to recoup losses incurred in the mid-1990s.¹² Health care spending per capita increased by nearly 9 percent in 2001 and, although projected to slow somewhat, will probably continue to grow by 7 percent annually for the next decade. Prescription drugs remain the fastest growing item, but acceleration in hospital costs is also a troubling development. Utilization of health care services, after being relatively flat in the mid-1990s, is rising, reflecting more use of hospital outpatient services, more prescription drugs, more physician visits, and more emergency room use.

Rather than attack the underlying causes of the increases, our "pass the buck" system of health insurance responds automatically during a period of rising costs by shifting costs onto another party: from one employer to the next, from employers to

Our “pass the buck” approach to health insurance tends to shift costs from one payer to another. Of the roughly 120 million American workers, only about 70 million receive coverage through their own employers.

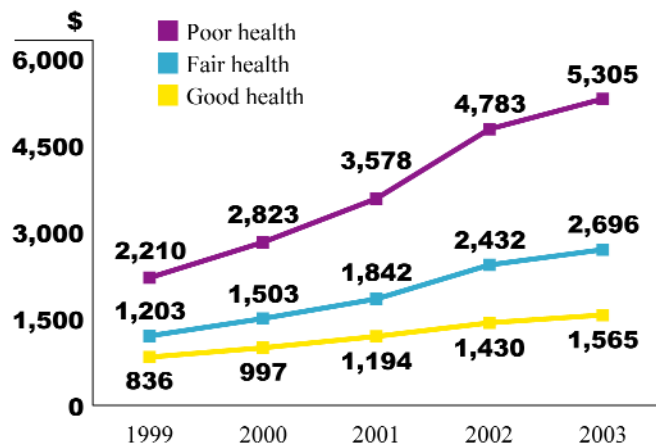
Insurance coverage for U.S. workers, ages 19-64



*Includes individually purchased coverage and “don’t know” responses. Source: Collins et al., *On the Edge: Low-Wage Workers and Their Health Insurance Coverage*, The Commonwealth Fund, April 2003.

Among Medicare+Choice enrollees, out-of-pocket spending has increased most dramatically for the sickest beneficiaries — raising serious questions about our reliance on private managed care plans to cover the elderly.

Estimated total annual out-of-pocket spending for Medicare+Choice enrollees



Gold and Achman, *Average Out-of-Pocket Health Care Costs for Medicare+Choice Enrollees Increase 10 Percent in 2003*, The Commonwealth Fund, August 2003.

workers, from federal government to state governments and back, and from insurers generally to safety net hospitals serving the uninsured. Most employers provide health insurance to their workers – but 25 million workers are covered either by another employer or by public programs.¹³ Employers who insure their workers have also been increasing deductibles and employee premiums. Far more energy is invested in shifting costs than in enhancing efficiency or quality of health care.

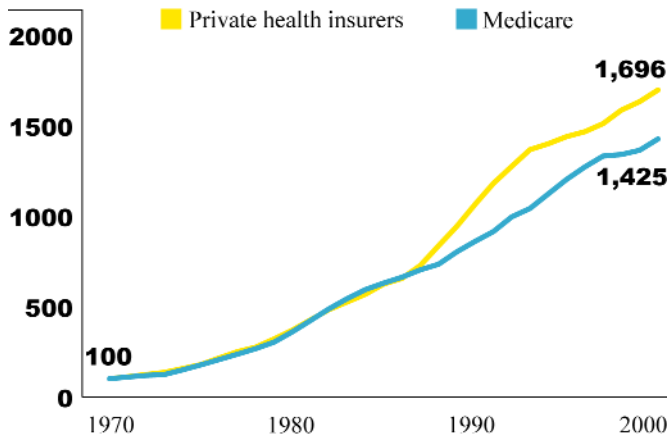
Fragmentation contributes to higher costs, as changes in families’ economic and personal circumstances cause constant churning in insurance coverage. Sixty-two million people – one of four Americans – were uninsured at some point during 2000, and 85 million were uninsured at some point during the four-year period 1996–1999.¹⁴ In 2002, the administrative costs of private and government insurance totaled \$111 billion, a major portion of which was incurred as people enrolled, disenrolled, re-enrolled, and changed insurance coverage and plans.

Insurance companies also engage in cost-shifting. They respond to rising costs by becoming more selective about whom they cover and seeking to attract favorable risks, not primarily by innovating to improve quality and efficiency. A Fund-supported study¹⁵ found that, over the five years from 1999 to 2003, increases in cost-sharing by private plans participating in Medicare had the cumulative effect of increasing out-of-pocket costs for seniors in poorer health by an estimated 140 percent. Selective use of increased deductibles and copayments may suggest an underlying strategy of discouraging enrollment and retention of sicker enrollees.

The belief that private insurance is more “efficient” than public programs is deeply

One measure of Medicare's efficiency is its relatively low rate of per-enrollee payment for key services, including hospital care, physician and clinical services, durable medical equipment, and other professional services.

Growth index, per enrollee payments for comparable services



Boccuti and Moon, "Comparing Medicare and Private Insurers: Growth Rates in Spending Over Three Decades," *Health Affairs* 22 (March/April 2003).

entrenched. Yet a recent Fund-supported study¹⁶ comparing the growth in per-enrollee payments for comparable services in Medicare and private insurance found that Medicare outperformed private insurance over the long term. Medicare uses its considerable purchasing clout to obtain favorable payment rates from providers, and its administrative costs are considerably lower than those of private insurers or managed care plans.

Expanding the reach of insurance coverage and increasing its efficiency are essential to improving the performance of the American health care system and ensuring that the benefits of modern medicine are available to all. Patients can be encouraged to help, too, through incentives to receive preventive services, for example, or to opt for less-expensive, therapeutically equivalent medications. Insurance can be designed to reduce wasteful spending on

administration and reward hospitals, physicians, and other providers for high-quality, cost-effective care.

RETHINKING ASSUMPTIONS ABOUT COST AND QUALITY

The idea that high quality means high costs is a matter of faith in the United States. Indeed, our health care system is perceived to be the best in the world in part because we spend more than any other country. Yet startling new evidence suggests the absence of a systematic relationship between cost and quality.

A team of investigators at Dartmouth Medical School has discovered large variations in health spending among regions of the country, with no evidence that health outcomes are better in higher spending regions.¹⁷ Similarly, an analysis by the federal Medicare Payment Advisory Commission found that the quality of care is lower for Medicare beneficiaries in states with higher rates of per person spending.¹⁸ An analysis of cost and quality of care at American hospitals by Sir Brian Jarman at the Institute for Healthcare Improvement documented a three- to five-fold difference in cost and quality for different diagnoses but no systematic relationship between quality and cost.¹⁹ The findings are provocative, yet more refined analysis will be needed to develop effective solutions to improve quality, eliminate wasteful or ineffective care, and increase efficiency.

High-quality care means providing the right care in the right way at the right time. The right care sometimes increases immediate costs and sometimes reduces them but tends overall to generate value by lengthening life expectancy, reducing illness, and enhancing patient functioning. Through a program at New York City's Coney Island Hospital, for

example, children and teenagers with asthma are able to dial in readings from their peak flow meters, which are monitored by nurses who respond quickly to any sign of trouble. The result has been a dramatic drop in inpatient admissions and emergency room use.

Poor-quality care can mean underuse of certain services, such as screening or treatment for diabetes, depression, and other conditions. It can also mean overuse of services that provide no benefit or, like antibiotics to treat upper respiratory infections in children, can produce harmful effects. Poor quality can mean errors that endanger patients' health and increase costs, as when a surgical patient needs to be readmitted to treat an infection.

A new study²⁰ by researchers at RAND shows that poor-quality care, especially underuse of effective services, is pervasive. Examining medical records and performance on 439 indicators of quality of care for 30 acute and chronic conditions, the investigators found that patients received the recommended care only 55 percent of the time. Poor care occurs not because physicians are poorly trained or incompetent but because systems that ensure that patients get the right care at the right time are scarce. These include reminders to patients for preventive services, prompts to physicians about appropriate medications or procedures, and techniques such as bar coding or computerized systems for recording doctors' orders.

With support from the Fund, researchers Sheila Leatherman and Don Berwick, M.D., produced a set of case studies²¹ of organizations that mounted quality improvement efforts. The interventions rarely generated savings to the hospital or health system, even when they succeeded in improving quality and

saving lives. In one example, Detroit's Henry Ford Health System used pharmacists to monitor patients with high cholesterol, an innovation that increased effective control from 53 percent of patients to 84 percent.²² The extra cost of pharmaceutical monitoring was not reimbursed by insurance, however, and the potential payoff in reduced heart disease was too far in the future to benefit the organization. Similarly, Children's Hospital in San Diego cut the length of stay for hospitalized pediatric asthma patients in half by instituting a best-practice clinical protocol for physicians.²³ That change actually lost money for the hospital, since the state's MediCal program pays a daily rate for hospitalized patients. The investigators conclude that reimbursement methods must change if innovations to improve quality are to become widespread.

Some private purchasers have made quality a priority. The Leapfrog Group, a coalition of major employers' health benefit plans and public program purchasers, has issued quality standards and provided financial incentives for enrollees to seek care at hospitals with stronger quality records. Bridges to Excellence is a new employer initiative to reward "gold standard" care. Despite these promising developments, a Fund-supported project found that examples of "value-based purchasing" are relatively limited.²⁴

Public programs have also been slow to embrace measures to reward better care, but some interesting examples show the potential of using health insurance coverage to leverage quality improvement. A Fund-supported study²⁵ documented Rhode Island's Rite Care program for low-income children, which provides bonuses to participating managed care plans that meet quality targets. A new

policy of providing coverage to women for two years post-partum has made family planning services more available and generated savings by reducing the number of births annually. Prenatal and obstetrical care has improved, lead poisoning screening has increased, and childbirth parity (births to a mother more than 18 months apart) has increased.

Medicare has also begun recently to provide bonuses to hospitals that meet quality performance targets and reduce payments to hospitals that fail to improve over a three-year period. Community health centers are participating in learning collaboratives to improve care for patients with chronic conditions such as diabetes. An evaluation, supported in part by the Fund, will examine the impact on quality, but preliminary indications show improvements in glucose control, blood pressure management, and patient self-management. The Veterans Administration has undergone a major organizational transformation focused on modern information technology and quality improvement processes; as a result, the share of patients meeting quality targets for prevention, chronic disease management, and palliative care has doubled over the past five years.²⁶

Private health care systems are also beginning to embrace such techniques. The Council of Accountable Physician Practices, which includes many of the nation's largest and most prestigious medical groups, totaling more than 17,000 physicians, has focused on quality, efficiency, and a culture of performance measurement, continual learning, innovation, and technology readiness. It has achieved HEDIS quality indicator scores 22 percent above the national averages for managed care plans,

better financial performance, and comparable patient satisfaction.

These examples are encouraging, but they are far too isolated and their influence on the health care system has been dampened by the high cost of modern information technology and a shortage of benchmarks against which to measure the performance of individual providers. Creating systems that prompt and reward doing the right thing at the right time will take a major shift in the culture of health care delivery.

PUTTING THE PATIENT FIRST

One place to begin the necessary cultural change is with a careful look at what patients want as opposed to what is convenient for physicians, what makes money for hospitals and managed care plans, or what saves money for employers or taxpayers. "Consumer-driven health care" is the latest buzzword, but the term is deceptive. The real objective is to shift health care costs to employees and drive the patient to less expensive providers or out of the health care system altogether. Strategies such as these may well alienate employees and trigger a backlash, especially when the economy rebounds and a labor shortage resurfaces.

A more effective strategy would be to design insurance and care around what patients need, then reward hospitals and physicians that provide that care in a high-quality, patient-centered, cost-effective manner. Patient incentives can play a supportive role by urging patients to be active partners in their care, encouraging healthy behavior, or removing financial barriers to preventive care. But it is important not to lose sight of the central objective: to provide care of

scientifically proven effectiveness, delivered in the way and at the time patients want it.

One of the most exciting recent developments is “advanced access,” a process by which doctors’ offices and clinics redesign their practices to provide same-day appointments. In Boston, the Institute for Healthcare Improvement has brought practice teams together to learn effective techniques. In New York, the Fund provided support that enabled the Primary Care Development Corporation to create learning collaboratives that have transformed primary care clinics serving low-income patients.²⁷ Because patients are able to get appointments quickly when they need them, missed appointments are reduced, physician time is used more efficiently, patients are more satisfied, staff members feel less hassled, and everyone wins.

A few pediatric practices around the country are also responding to the concerns of parents, who want to know if their young children are growing and developing normally and who want help with behavioral problems, as research by the Fund has shown.²⁸ The Fund has supported a number of promising approaches. Healthy Steps, which adds developmental services to pediatric practices, has greatly increased parents’ satisfaction with care, improved the quality and continuity of care, reduced use of severe physical discipline by parents, and fostered loyalty to the practice.²⁹ In another Fund-supported model, Assuring Better Child Health and Development (ABCD), coordinated by the National Academy for State Health Policy, four state Medicaid programs have helped ensure access to developmental services for low-income parents and children.³⁰ By incorporating child development appraisals into regular well-baby visits, ABCD has

raised levels of parent satisfaction, helped pediatric clinics respond to parent concerns, and increased specialized services for children with behavioral or developmental delays. In general, however, current financing systems do not reward approaches such as these, and changes will be necessary under Medicaid, the federal Children’s Health Insurance Program (CHIP), and private insurance if they are to spread more broadly.

One of the most important challenges for the American health care system of the future is providing culturally competent care to an increasingly diverse population. A Fund report summarizes model programs that have reorganized care to respond to the needs of a multicultural patient population.³¹ The authors recommend widespread efforts to hire and promote minorities in the health care workforce, involve community representatives in planning and quality improvement, provide on-site interpreters to assist patients, and generate health information geared to patients’ language, culture, and literacy level. Collecting data on the care of specific racial and ethnic populations will also be needed in order to target quality improvement efforts.

Change is also coming to some of the nation’s nursing homes. Traditionally, nursing homes have been organized along rigid lines. Residents have been awakened, bathed, and fed according to fixed schedules, with little flexibility for front-line staff to honor preferences or respond to individual needs. But a group of inspiring nursing home leaders has begun to show the way toward a different model of care. Fund-supported evaluations of Wellspring in Wisconsin,³² a select group of innovative nursing homes in the Beverly chain, and the Green House

project in Mississippi are compiling encouraging evidence of increased resident satisfaction, lower staff turnover, and improved quality of care and life. Fund support for the Pioneer Network,³³ a new coalition dedicated to advancing a resident-centered culture in nursing homes, is helping to spread the word through its website and annual meetings.

A HIGH PERFORMANCE HEALTH CARE SYSTEM

We have the world's costliest health system, yet we fail to make care accessible to everyone and fall far short of providing the patient-centered, safe, high-quality care that we know is possible. The conclusion is inescapable: there is room for improvement. Only by facing the fact squarely and putting into action the best ideas and examples from around the country and the world can we achieve a health care system that truly meets our needs and aspirations.

To build a truly high performance health system, bold action is required. The following steps would start us on course:

- **Provide automatic, affordable health insurance for all.** Fund staff recently proposed a framework³⁴ for extending health insurance coverage to all Americans, building on existing sources of group insurance. Proposed strategies include adding to employer coverage, opening up a Congressional Health Plan for small businesses and uninsured individuals, and expanding Medicare and CHIP. Automatic enrollment through the income tax system and graduated tax credits would make coverage affordable for all, while requiring only modest commitment of federal funding.
- **Put the patient first.** Physician practices, hospitals, nursing homes, and other health care

providers need to redesign practices and systems around what works for patients. Listening to patients, obtaining patient feedback, and involving patients in governance and care processes can all help. Simplifying care and having a trusted personal physician or advanced practice nurse can both improve safety and adherence to recommended care. Insurers and regulators can support change by rewarding care that is responsive to patients' preferences.

- **Report cost and quality data publicly.** The Medicare program has been a leader in posting nursing home quality data on its website, but those efforts are just a modest beginning. If we are serious about doing better, we need to know where we stand. Data reporting should cover physicians, hospitals, nursing homes, other health care providers, and health plans.
- **Invest in health information technology.** Other countries are quickly surpassing the United States in adopting electronic medical records and prescribing systems.³⁵ Their governments have invested in infrastructure and established the necessary standards, and the United States needs to do the same.
- **Promulgate guidelines on quality and effectiveness.** It is long past time to establish a scientific basis for all health care services – not just new drugs, but consultations, procedures, and tests. This could be accomplished by establishing a new national institute on clinical effectiveness.
- **Pay for performance.** Medicare and private insurers tend to pay standard rates, regardless of quality, despite the fact that errors and other defects can produce significant additional costs. The federal Center for Medicare and Medicaid

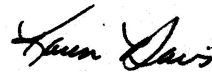
Services has already begun modest testing of pay-for-performance rewards. Those efforts should be expanded substantially and best practices documented and disseminated.

Medicare's leadership could also be instrumental in moving private payers, which so far have been slow to institute value-based purchasing strategies.

- **Demonstrate new approaches.** The Institute of Medicine issued a report in the fall of 2002 calling for statewide demonstrations of health insurance coverage for all, model chronic care and primary care initiatives, information technology, and medical malpractice.³⁶ A ten-year federal commitment of \$50 billion would go a long way toward putting those recommendations into action in a number of states.
- **Invest in research.** We urgently need to gather evidence on what works to improve care, eliminate waste, and promote efficiency. The federal government pays \$455 billion annually for health care but devotes only \$300 million to the Agency for Healthcare Research and Quality.

The Agency's national report³⁷ on the quality of American health care could be an important starting point, but it should be followed with significant new investment in research.

The Commonwealth Fund seeks to be a catalyst for change by identifying promising practices and contributing to solutions that could help us achieve a high performance health system. The Fund's role is to help establish a base of scientific evidence on what works, mobilize talented people to transform health care organizations, and collaborate with organizations that share its concerns. Our communications efforts enable us to spread the word, share knowledge and experience, and urge the agenda forward. At this critical juncture, we hope our work will contribute to the creation of a bold new strategy to make high-quality health care accessible to all Americans.



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